TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Green Oaks Fort Worth

Respondent Name
Chubb Indemnity Insurance Co

MFDR Tracking Number
M4-16-0997-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The date of service 12/10/14 – 1/14/15 was billed the following day. I have not received any correspondence to any of the following dates of service. After not receiving anything I rebilled on 02/18/2015. Please reprocess attached claims for additional payment."

Amount in Dispute: $1,636.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 16, 2015. 28 Texas Administrative Code 133.307 (d)(1) states, "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received, this dispute will be based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 10, 2014 through January 14, 2015	Physical Therapy Services	$1,636.00	$1,007.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements of medical bill submission by health care provider.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – Time Limit for filing claim/bill has expired
   - W3 - Appeal/reconsideration
   - 193 – Original payment decision maintained
   - P14 – Pymt is included in another svc/proc same day
   - 234 – This procedure is not paid separately

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 29 – "Time limit for filing claim/bill has expired." 28 Texas Administrative Code §133.20 (b)

   Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   Review of the submitted information finds:

   - Document titled, "Bill Validation Message" shows service range 12/10/2014 thru 12/10/2014 was submitted to "Chubb Ins WC" on December 15, 2014. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range 12/11/2014 thru 12/11/2014 was submitted to "Chubb Ins WC" on January 7, 2015. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range 12/19/2014 thru 12/19/2014 was submitted to "Chubb Ins WC" on January 7, 2015. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range 12/23/2014 thru 12/23/2014 was submitted to "Chubb Ins WC" on January 9, 2015. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range 12/29/2014 thru 12/29/2014 was submitted to "Chubb Ins WC" on January 9, 2015. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range 12/30/2014 thru 12/30/2014 was submitted to "Chubb Ins WC" on January 17, 2015. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range January 5, 2015 thru January 5, 2015 was submitted to "Chubb Ins WC" on January 17, 2015. That was accepted by the payor.
   - Document titled, "Bill Validation Message" shows service range January 14, 2015 thru January 14, 2015 was submitted to "Chubb Ins WC" on January 19, 2015. That was accepted by the payor.

   Based on the above, the requestor has provided evidence to support the timely submission of claims to the correct worker's compensation carrier. Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   28 Texas Administrative Code 134.203 (b) states,

   For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Per Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, 10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment.

The calculation of the maximum allowable reimbursement is as follows:

- Procedure code 97110, service date December 10, 2014. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (55.75/35.8228) x $32.00 = $49.80. This procedure has the highest PE for this date. This unit is paid at $49.80.
- Procedure code 97140, service date December 10, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $32.00 x (practice expense, 0.40 ÷ 2 = 0.20) = $23.89, (55.75/35.8228) x $23.89 = $37.18. The PE reduced rate is $37.18.
- Procedure code G0283, service date December 10, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $13.82 x (practice expense, 0.20 ÷ 2 = 0.10) = $12.43, (55.75/35.8228) x $12.43 = $19.34. The PE reduced rate is $19.34.
- Procedure code 97110, service date December 11, 2014. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (55.75/35.8228) x $32.00 = $49.80. This procedure has the highest PE for this date. This unit is paid at $49.80.
- Procedure code 97140, service date December 11, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $32.00 x (practice expense, 0.40 ÷ 2 = 0.20) = $23.89, (55.75/35.8228) x $23.89 = $37.18. The PE reduced rate is $37.18.
- Procedure code G0283, service date December 11, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $13.82 x (practice expense, 0.20 ÷ 2 = 0.10) = $12.43, (55.75/35.8228) x $12.43 = $19.34. The PE reduced rate is $19.34.
- Procedure code 97110, service date December 19, 2014. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (55.75/35.8228) x $32.00 = $49.80. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $49.80. The PE reduced rate is $32.00 x (practice expense, 0.44 ÷ 2 = 0.22) = $24.96, (55.75/35.8228) x $24.96 = $38.44. The total is ($49.80 + 38.44) = $88.24.

- Procedure code 97140, service date December 19, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $32.00 x (practice expense, 0.40 ÷ 2 = 0.20) = $23.89, (55.75/35.8228) x $23.89 = $37.18. The PE reduced rate is $37.18.
- Procedure code 97110, service date December 23, 2014. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (55.75/35.8228) x $32.00 = $49.80. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $49.80. The PE reduced rate is $32.00 x (practice expense, 0.44 ÷ 2 = 0.22) = $24.96, (55.75/35.8228) x $24.96 x 2 units = $77.68. The total is ($49.80 + 77.68) = $127.48.
- Procedure code G0283, service date December 23, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $13.82 x (practice expense, 0.20 ÷ 2 = 0.10) = $12.43, (55.75/35.8228) x $12.43 = $19.34. The PE reduced rate is $19.34.
- Procedure code 97110, service date December 29, 2014. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (55.75/35.8228) x $32.00 = $49.80. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $49.80. The PE reduced rate is $32.00 x (practice expense, 0.44 ÷ 2 = 0.22) = $24.96, (55.75/35.8228) x $24.96 = $38.44. The total is ($49.80 + 38.44) $88.24.
- Procedure code G0283, service date December 29, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $13.82 x (practice expense, 0.20 ÷ 2 = 0.10) = $12.43, (55.75/35.8228) x $12.43 = $19.34. The PE reduced rate is $19.34.
- Procedure code 97110, service date December 30, 2014. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (55.75/35.8228) x $32.00 = $49.80. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for the second unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $49.80. The PE reduced rate is $32.00 x (practice expense, 0.44 ÷ 2 = 0.22) = $24.96, (55.75/35.8228) x $24.96 = $38.44. The total is $88.24.
- Procedure code G0283, service date December 29, 2014. This procedure does not have the highest PE for this date. The PE reduced rate is $13.82 x (practice expense, 0.20 ÷ 2 = 0.10) = $12.43, (55.75/35.8228) x $12.43 = $19.34. The PE reduced rate is $19.34.
- Procedure code 97110, service date January 5, 2015. This procedure does not have the highest PE for this date. The PE reduced rate is The PE reduced rate is $32.38 x (practice expense, 0.44 ÷ 2 = 0.22) = $25.26, (55.75/35.8228) x $25.26 = $39.70 at 2 units is $79.40.
- Procedure code 97530, service date January 5, 2015. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (56.2/35.7547) x $34.94 = $54.92. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. This unit is paid at $54.92.
- Procedure code G0283, service date January 5, 2015. This procedure does not have the highest PE for this date. The PE reduced rate $13.85 x (practice expense, 0.20 ÷ 2 = .10) = $12.45, (55.75/35.8228) x 12.46 = $19.58.

- Procedure code 97010, service date January 5, 2015, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.
- Procedure code 97110, service date January 14, 2015. This procedure does not have the highest PE for this date. The PE reduced rate is The PE reduced rate is $32.38 x (practice expense, 0.44 ÷ 2 = 0.22) = $25.26, (55.75/35.8228) x $25.26 = $39.70 at 2 units is $79.40.
- Procedure code 97530, service date January 14, 2015. The MAR is calculated as follows (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = TX FEE MAR or (56.2/35.7547) x $34.94 = $54.92. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. This unit is paid at $54.92.
- Procedure code G0283, service date January 14, 2015. This procedure does not have the highest PE for this date. The PE reduced rate $13.85 x (practice expense, 0.20 ÷ 2 = .10) = $12.45, (55.75/35.8228) x 12.46 = $19.58.
- Procedure code 97010, service date January 14, 2015, has a status indicator of B, which denotes a bundled code. Payments for these services are always bundled into payment for other services to which they are incident.

3. The total allowable reimbursement for the services in dispute is $1,007.84. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $1,007.84. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,007.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,007.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		February , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.